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Outcomes of the Sanctuary Model in an Education Setting

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Philadelphia College of Osteopathic Medicine

Department of Psychology

OUTCOMES OF THE SANCTUARY MODEL IN AN
EDUCATION SETTING

Brianna Matey

Submitted in Partial Fulfillment of the Requirement

for the Degree of Doctor of Psychology

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**PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE
DEPARTMENT OF PSYCHOLOGY**

Dissertation Approval

This is to certify that the thesis presented to us by Brianna Tarry
on the 6 day of November, 2013, in partial fulfillment of the
requirements for the degree of Doctor of Psychology, has been examined and is
acceptable in both scholarship and literary quality.

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Abstract

This study examines the short-term outcomes of implementing the Sanctuary Model in an emotional support educational setting over the 2011-2012 school year. The frequency of restraints, the therapeutic environment, and job satisfaction were evaluated pre and post implementation of the model. Study participants included teachers, teacher aides, and a licensed clinical social worker at a nonprofit behavioral health care organization in the mid-Atlantic region. Results indicated similar numbers of restraints employed in the 2010-2011 school year compared to the 2011-2012 school year. Three out of 10 domains in the therapeutic environment measured by the Community Oriented Program Environment Scale (COPES-R) were rated one standard deviation lower than the normative sample at the first administration compared to only one significant domain at the last administration of the COPES-R. There were no significant changes in job satisfaction from pre to post implementation of the Sanctuary Model. However, 14 job satisfaction variables declined after 1 year of implementing of the Sanctuary Model, which is consistent with previous studies (NASMHPD, 2009). Despite the non significant results of the current study, informative trends were noted and future directions were outlined. A further review of the significant environmental and clinical variables related to restraint use may provide useful information in decreasing restraint use.

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Introduction

Statement of the Problem

The pervasive use of restraints is documented throughout human service sectors as a means of containing a person's behavior in order to ensure safety for the individual and staff. However, restraints can be dangerous and have not been supported as an effective method of building a safe therapeutic environment (Child Welfare League of America, 2000). Despite the physical and psychological risks associated with restraint use, they are utilized now as a last-resort measure to ensure the physical safety of the individual and staff within school, psychiatric, and hospital settings (The Council for Children with Behavioral Disorders, 2009a).

Three types of restraints are employed in the human service field: mechanical, chemical, and physical restraints. The focus of the current research is limited to the use of physical restraints, as this type of restraint is widely used across therapeutic settings, hospitals, and schools. Physical restraints are defined as restriction of an individual's movement by way of one or more persons constraining the individual in an effort to maintain the safety of the individual and those in close proximity (The Council for Children with Behavioral Disorders, 2009a).

One setting in need of further assessment of the use and effects of restraints is the school environment. Research surrounding the use of restraints in school settings is limited (The Council for Children with Behavioral Disorders, 2009a; Mohr, LeBel, O'Halloran, & Preustch, 2010). Although teachers routinely receive physical-restraint training, no national accrediting body assesses the use and effectiveness of restraints in school settings (The Council for Children with Behavioral Disorders, 2009b). Moreover,

oversight and national reporting standards for restraint use within the school system are limited. The lack of reporting standards makes it difficult to obtain an accurate estimate of the rate of restraint use in school settings. However, researchers hypothesize that the use of physical restraints in schools has increased as a result of the large number of students with emotional and behavioral needs being placed in general-education classrooms (Child Welfare League of America, 2000).

An increase in school restraint use is concerning given the potential negative effects of restraint use. Both individuals employing physical restraints and the individual being restrained may incur injuries. Further, restraints have resulted in secondary trauma on staff and negatively impact the therapeutic environment. Given these potential dangers, researchers have attempted to understand the effects of using physical restraints on staff and individuals.

The psychological effects on staff members restraining others include experiencing fear, a rush of adrenaline while implementing the restraint, and posttraumatic stress symptoms (The Council for Children with Behavioral Disorders, 2009a). As the use of physical restraints continues, the psychological stressors associated with restraints can be detrimental to the well being of staff and to the therapeutic environment (Bonner, Lowe, Rawcliffe, & Wellman, 2002). For example, secondary trauma can manifest in staff members when they participate in restraints (Farragher & Yanosy, 2005). Some of the symptoms staff can experience include increased physical aggression and memories of past negative incidences, and restraints can negatively impact the therapeutic relationship (Bonner et al., 2002).

The data on the number of individuals who have died or suffered injuries as a result of restraint use have been difficult to track because of a lack of reporting guidelines prior to 2001, when the reporting policy was created (Dierkers, 2001; Health Care Financing Administration, 2001). The Child Welfare League of America (2000) estimated that eight to 10 children die each year as the result of physical restraints. The Coalition Against Institutionalized Child Abuse (2010) reported that during the 9-year period from 1988 to 1998, 27 reported deaths were related to restraints, compared to an 8-year period from 1998 to 2006, when 48 deaths related to physical restraints were reported. The increased rates in restraint-related deaths might be a result of the standardization of reporting laws that began in 2001. However, the potential dangers against restraints underscore the need for careful monitoring and the development of practices to reduce restraint use.

The sanctuary model, based on principles of nonviolence, has become a promising practice as an effective method in reducing restraints and physical injuries (Banks & Vargas, 2009). The Sanctuary Model is a trauma-informed recovery model that emphasizes the need for a safe, supportive, nonviolent, and stable therapeutic environment (Banks & Vargas, 2009). The Sanctuary Model was developed from the recovery and resiliency model and adopted an approach built on the commitment to safety and nonviolence (Bloom, 1994; Bloom, 2000a; Bloom, 2005). Overall the Sanctuary Model highlights the treatment environment as a core for modeling and establishing healthy relationships (Madsen, Blitz, McCorkle, & Panzer, 2003).

Research on the Sanctuary Model indicates that it can be effective in reducing the rates of restraints, increasing positive support in the therapeutic environment, increasing

job satisfaction, and improving treatment outcomes in residential treatment facilities, schools, inpatient hospitals, and domestic violence shelters (Bloom, 2000a; Banks & Vargas, 2009; Madsen et al., 2003). However, research is limited in the implementation and short-term outcomes of the Sanctuary Model in school-based settings. The Atlantic County School District was awarded a grant in 2001 to implement the Sanctuary Model; however, no formal results have been published at this time. Additionally, Banks and Vargas (2009) published results from five public schools that piloted the Sanctuary Model in North Carolina and New York. The schools reported a decrease in restraint use, critical incidents, and staff turnover, as well as improved treatment outcomes. Research and evaluation of this model, such as short-term outcome studies, may aid in the success of long-term implementation and assistance in least restrictive and positive support interventions for both students and staff.

Purpose of the Study

The Sanctuary Model provides a framework for a nonviolent and positive support environment within the school setting. The current study assesses the potential efficacy and impact of the sanctuary model in a school-based behavioral-health program in the mid-Atlantic region.

The goal of the study is to explore the impact of the Sanctuary Model in a school-based emotional-support program in regard to restraints, the therapeutic environment, and job satisfaction. The efficacy and impact of the model are assessed by measuring the frequency of restraint use, measuring domains in the therapeutic environment measured by the Community Oriented Program Environment Scale, and assessing job satisfaction pre and post-implementation of the sanctuary model in a school-based behavioral-health

program. Further research on the impact of restraints on the therapeutic environment may provide interventions that could yield positive support interventions, which are less restrictive and intrusive to the child.

This study explores the impact of the sanctuary model by implementing trauma-focused care, attempting to utilize the least restrictive environment for children by reducing the number of restraints, and attempting to facilitate positive change in the therapeutic environment. The following literature review outlines the historical and current use of restraints and risk factors. The review summarizes current governing bodies and associated research that have shifted the training and reporting guidelines of restraint use. Such factors as job satisfaction, staff burnout, and domains within the therapeutic environment directly impacting service delivery and clinical outcomes are then outlined. Finally, the conclusion of the literature review outlines the sanctuary model and research related to outcomes, barriers, and criticisms of the model.

Chapter 2: Review of the Literature

Definitions and Overview of Restraints

A restraint is any means by which one or more persons restrict another's ability to physically move or have normal access to his or her body (The Council for Children with Behavioral Disorders, 2009a). The most commonly utilized restraints in psychiatric and educational settings are mechanical, chemical, and physical. Mechanical restraints are devices placed on an individual that restrict his or her movements, such as a straightjacket. Chemical restraints utilize drugs to restrict the individual's freedom to move. Physical restraints, the focus of this study, involve having one or more persons physically restricting the movement of another.

There are two types of restraint positioning, supine and prone. A supine restraint occurs when an individual is on his or her back and two staff members each hold down one arm and one leg. In contrast, a prone restraint occurs when the individual is face down on the ground. Two staff members perform the prone restraint. One staff member is at the head holding down the individual's arms, while the second staff member secures the individual's legs.

Physical risks can result from administering prone restraints. One major risk is decreased lung functioning and possible death from positional asphyxia, which is defined as a fatality caused by the restraint position inhibiting adequate breathing for the individual (Mohr, Petti, & Mohr, 2003). Despite these risks, restraints have been used to constrict individuals' movements across school settings, in-patient facilities, juvenile systems, and adult hospitals without a full understanding of outcomes (The Council for Children with Behavioral Disorders, 2009a). Data are limited with regard to history and

current frequency of restraint use in schools because of vague reporting guidelines and lack of state and national accrediting policies for educational institutions (The Council for Children with Behavioral Disorders, 2009b). Despite limited data in both the educational and mental-health professions, accrediting bodies and federal agencies have created initiatives to direct and support the decreased use of restraints in order to minimize the dangers associated with the use of restraints.

In June 2010, the Pennsylvania Department of Public Welfare clarified and outlined guidelines for the use of restraints in children's mental-health residential and day facilities. This bulletin sought to clarify procedural and reporting requirements for children's residential and day facilities in Pennsylvania and attempted to utilize the guidelines of the Pennsylvania Department of Education. Pennsylvania law requires that while applying a restraint, staff members change the position of the restraint, or the staff person applying the restraint, at least once every ten consecutive minutes. Additionally, Pennsylvania requires that a staff person not applying the restraint must observe and document the physical and emotional state of the individual at least every 10 minutes during the manual restraint's application (Commonwealth of Pennsylvania Department of Public Welfare, 2009). The current plan bans any restraint that applies pressure or weight on an individual's respiratory system.

In alignment with the Pennsylvania Department of Public Welfare guidelines, the Pennsylvania Department of Education published its own standards in September 2010. The Pennsylvania Department of Education outlined their stance on using restraints and, in particular, prone restraints. It banned prone restraints in school settings while outlining

the need for training in de-escalation measures, positive behavioral support plans, and monitoring of restraints in public schools (Pennsylvania Department of Education, 2010).

Historically, the fields of human service, medicine, juvenile justice, and education have employed restraints. Staff use restraints as a means of controlling a person's behavior in order to ensure safety for the individual, staff, or others within the environment. Formerly, the use of restraints in education was reserved primarily for special education students. At present, any student who is in danger of hurting him or herself or others may require restraining. Concern from many service communities is growing with regard to possible physical and psychological trauma that could result from restraining. Today, most therapeutic and educational programs employ restraints solely in emergency or crisis situations in order to prevent injury to the individual or others (The Council for Children with Behavioral Disorders, 2009b).

Physical and Psychological Impacts from Restraints

The mental-health field has justified the use of restraints as a method for reducing an individual's risk of harm to self and others. Nevertheless, the coercive nature, injuries, and deaths associated with restraint use have raised questions and concerns about whether or not these procedures violate basic human rights. Restraints have resulted in adverse consequences for the individuals restrained and those employing the restraints. These include physical injury, psychological trauma, and death (Mohr et al., 2010). The Harvard Center for Risk Analysis estimated 50 to 150 deaths annually are the direct result of restraint use (Mohr et al., 2010).

The literature acknowledges that both prone and supine restraints have resulted in death and injury. Nunno, Holden, and Tolar (2006) examined 45 child and adolescent

restraint-related deaths in residential placements in the United States between the years of 1993 to 2003. The results indicated that 28 of the deaths occurred while the child was in a prone restraint. In 25 of the fatalities, asphyxia was the reported cause of death. Resulting from the position of the individual placed in the prone restraint, the most common cause of death is positional asphyxia.

Although researchers consider prone restraints more controversial than supine and have banned them in public educational institutions and mental health facilities, supine restraints have resulted in similar injuries and fatalities. Specifically, Nunno et al. (2006) identified 17 deaths that were a result of children being placed in supine restraints. Furthermore, injuries can occur while the individual is taken to the ground during the restraint, or as a result of pressure on bones, joints, diaphragm, or neck (The Council for Children with Behavioral Disorders, 2009a).

Facilitators implementing restraints are also at risk for physical and emotional harm caused by the increased stressors. Along with the physical risks of restraint use, there are psychological risks associated with restraints. Mental health professionals have reported negative physical and emotional effects from implementing restraints. These include short-term effects such as bite marks, broken bones, fear, and adrenaline rush from the physical confrontation, and long-term effects such as posttraumatic stress disorder (The Council for Children with Behavioral Disorders, 2009a; Mohr et al., 2010). Restraints can result in increased stress within program environments for staff and children. Consequently, restraints can create a negative treatment environment and increase the risk of secondary trauma or re-traumatization to individuals who have already experienced trauma. Results also indicate that preexisting physical or medical

conditions might increase the risk of harm resulting from restraint use (Mohr et al., 2010). Another risk factor resulting from restraints is staff burnout, caused by the potential physical and emotional stress that is experienced by staff (The Council for Children with Behavioral Disorders, 2009a; Curie, 2005; Farragher & Yanosy, 2005).

Staff Burnout and Job Satisfaction

Maslach, Schaufeli, and Leiter (2001) defined burnout as a psychological condition that is a result of chronic work stress. Maslach et al. (2001) defined three distinctive areas of burnout: emotional exhaustion, depersonalization, and lack of perceived accomplishment. Studies have detected burnout in staff in a variety of human service settings, including schools and hospitals, and in a range of staff, such as emergency responders, teachers, and military personnel (Hastings et al., 2004; Maslach et al., 2001).

The negative impact of staff burnout is evident in the work environment and staff's quality of life. Staff suffering from burnout report decreased job satisfaction, less productivity and commitment to the organization, and higher absenteeism (Lawson & O'Brien, 1994; Maslach et al., 2001). Staff affected by burnout and decreased job satisfaction may have an overall poorer work performance and lower quality of service delivery. For example, staff are more likely to lack empathy and may be more impatient with others when compared with those not affected (Shanafelt, Wipf, & Baker, 2002). The effects of staff burnout are also felt outside the work setting. Burnout has been linked to chronic illness, such as cardiovascular disease (The Council for Children with Behavioral Disorders, 2009a; Mohr et al., 2010). It has also been associated with fear and frustration, which continues the cycle of psychological stress (The Council for

Children with Behavioral Disorders, 2009a; Farragher & Yanosy, 2005; Mohr, et al., 2010). Overall, the negative symptoms of staff burnout may negatively affect not only the individual, but also other staff members and work production, which, in turn, impacts the clinical treatment for the individuals being served.

Certain factors aid in counteracting staff burnout and job dissatisfaction. Glisson and Hemmelgarn (1998) studied mental-health providers serving children and found that when organizations had higher job satisfaction, cooperation, and limited levels of conflict, service and treatment outcomes were of higher quality. Results reported by Mutkins, Brown, and Thorsteinsson (2011) suggested a positive work environment and social supports might minimize negative factors contributing to staff burnout. Research on the Sanctuary Model, discussed later in this review, indicates that improvements in staff job satisfaction buffer the effects of staff burnout through the seven commitments and techniques in the Sanctuary toolkit (Yanosy, Harrison, & Bloom, 2009).

Governing Bodies and Shift in Restraint Laws

Restraint use has garnered the national spotlight since the early 1990s (The Council for Children with Behavioral Disorders, 2009), when the *Hartford Courant*, a newspaper in Connecticut, reported that over a 10-year period during the 1990s, 142 restraint related deaths occurred in the United States (The Council for Children with Behavioral Disorders, 2009a). The news article then spurred an investigation into restraint procedures and subsequent changes to current laws.

In 1999, the United States General Accountability Office (USGAO) investigated the use of restraints in mental-health settings. Its report revealed patterns of misuse, abuse, injury, and death resulting from the use of restraints (USGAO, 1999a; USGAO,

1999b). The study stated that there was no consistent statewide system for reporting injuries or death from restraint use. As a result of the findings of this report, the USGAO asked the United States Health Care Financing Agency to establish regulations and strict standards on the use of restraints for mental-health-care facilities. The ensuing regulations required all facilities to file a report with Medicare or Medicaid if a patient died as a result of a restraint or hold (Mohr et al. USGAO, 1999a; USGAO, 1999b). These regulations provided the framework for many accrediting bodies to adopt best practice procedures for de-escalation techniques in the mental-health profession.

The regulations established throughout the late 1990s and early 2000s caused medical, psychiatric, and law enforcement agencies to implement strict rules governing the use of restraints. Accrediting bodies, such as the Joint Commission on Accreditation of Health Organization, National Association for Psychiatric Center for Children, and American Academy of Pediatrics, have published bulletins and enacted bylaws to address the use of restraints (The Council for Children with Behavioral Disorders, 2009a). The current regulations state that restraints are to be implemented only when less restrictive interventions have failed to effectively protect the patient and others from harm (Mohr, et al., 2010).

There have been notable changes in the use of restraints within settings as well as in quality training in restraint use since the publication of state legislation and standardized guidelines. Though restraint use still occurs in schools and mental-health facilities when an individual is in danger of hurting him or herself or others, a shift has occurred in the philosophy of the use of restraints, reporting standards, and trainings. The current regulations and legislation impacted the philosophy for using restraints by

shifting the standard for implementation of restraints from a type of therapeutic intervention to only occurring only as a last-resort effort to secure the physical safety for the individual or those surrounding the individual (Morgan, Hunt, & Georges, 2006; Commonwealth of Pennsylvania Department of Public Welfare, 2009). The philosophical change in restraint use has helped implement more positive proactive behavioral supports for individuals before resorting to physically restraining the individual in a reactive manner (Morgan et al., 2006; Pennsylvania Department of Education, 2010).

The next major change in restraint policy was in regard to reporting standards, which resulted from state guidelines. As discussed previously, from 1988 to 1998, the Coalition Against Institutionalized Child Abuse (2010), reported 27 deaths compared to 48 deaths from 1998 to 2006, which resulted from physical restraints. Due to the lack of reporting guidelines prior to 2001, facilities were not required to internally or externally report on restraints in the same manner. As a result of the lack of requirement to report restraint-related deaths, there could have been deaths that were not reported that were a result of restraint use. Currently, the regulations and accrediting bodies, such as the Joint Commission, require facilities to internally report each time a restraint is used and externally report each incidence of death or injury that is the result of a restraint (Morgan, et al., 2006).

Along with reporting standards, training and changes within the therapeutic environment have shifted the frequency of the use of restraints. Researchers have recommended a multitude of interventions to address the therapeutic milieu to help reduce the use of restraints. Interventions suggested to impact the therapeutic milieu

ranged from trainings for staff on coping with aggressive clients, verbal de-escalation techniques, and behavioral and functional assessment trainings to help build knowledge around a holistic and preventative approach to treatment (Morgan et al., 2006). Research suggests that organizations that strengthened the therapeutic environment have decreased restraint use (Azeem, Ajula, Rammerth, Binsfeld, & Jones, 2011; LeBel, Huckshorn, & Caldwell, 2010; Morgan, Hunt, & Georges, 2006).

Guidelines for Use of Restraints with Children

The Child Welfare League of America (2000) reported death and serious injuries, such as bites, damage to joints, scratches, and broken bones, as a result of physical restraints. In a study conducted in the state of New York, Altemari, Blint, Weiss, & Megan (1998) recorded that 94% of restrained individuals reported at least one complaint about the process while 40% felt the experience was psychologically abusive. Currently, laws and regulations passed by accrediting bodies are considered safeguards and standards for individuals' rights regarding restraints.

These aforementioned governing bodies have outlined the standard and best practice principles for agencies to employ. In 2009, the National Association of State Mental Health Program Directors (NASMHPD) published guidelines providing mental-health professionals with standard practices in order to minimize the use of restraints. The goal was to establish guidelines for the use of restraints in therapeutic treatment programs. The plan outlines the movement to eliminate restraints in a top down approach, beginning with leadership support for the organizational change and adherence to best practices. The guidelines emphasize the need for practice change, as well as training staff in de-escalation, restraint reduction management, and proper debriefing post

restraint. These guidelines, adopted by the Pennsylvania Department of Public Welfare, serve as a benchmark to guide internal policies and procedures surrounding restraint use in a variety of settings (Commonwealth of Pennsylvania Department of Public Welfare, 2009).

The Council for Children with Behavioral Disorders (2009b) published a report regarding restraints in the school setting. They found minimal research on the prevalence of restraint use because of the lack of incident reporting standards. In May 2009, the Council for Children with Behavioral Disorders established best practice principles in response to the limited published guidelines and standards. Some of the best practice principles include children receiving necessary educational and mental health supports in a safe and least restrictive environment, adequate staffing to support children, and positive behavioral support interventions. The Council for Children with Behavioral Disorders believes that, if followed, these principles could significantly reduce restraints within the school setting.

Coinciding with the Council for Children with Behavioral Disorders Best Practice Principles, the Department of Public Welfare published its guidelines on restraint reduction. In these guidelines, the Commonwealth of Pennsylvania Department of Public Welfare (2009) discussed the need to utilize trauma-informed care, which encompasses positive and proactive approaches when using restraints. The Substance Abuse Mental Health Service Administration (SAMHSA) (n.d.) define trauma-informed care as treatment that takes into account how trauma affects the life of an individual seeking services. Organizations that implement trauma-informed care consider past traumatic experiences as triggers that traditional service delivery approaches may aggravate.

Trauma-informed care allows these services and programs to be more supportive and avoid re-traumatization. Commonwealth of Pennsylvania Department of Public Welfare (2009) described trauma-informed care as the most effective tool for restraint reduction and prevention. Programs that apply trauma informed care demonstrate respect for the family and child's culture, meaningful collaboration with the family, and sensitivity to the child's past history of mental health needs. Trauma informed care begins with listening to the child and family. It allows staff to glean possible antecedents or triggers of behaviors that would warrant being restrained and to learn de-escalation techniques that may prevent restraint use. This approach provides the clinician or teacher a better understanding of the total person. By listening and observing, professionals can learn to and allow staff to employ preemptive measures to deescalate triggers, thus decreasing the need for restraint use.

The Recovery and Resiliency Movement

The basic principles of trauma-informed care have emerged from the recovery and resiliency movement. Recovery acknowledges that people can lead positive and productive lives despite a mental-health diagnosis. Resiliency is the act of utilizing internal and external qualities in the person to achieve an optimal quality of life (Ridgway, 2001). The recovery model envisions client empowerment and self-determination. This model enables clients to be more actively involved in the treatment process and encourages staff to address clients' needs, desires, and experiences, hence improving therapeutic environments and interactions and leading to fewer restraints. In recovery-oriented care, the treatment system is partially client designed and directed, and

reacts to the client's actions with controlling responses, like restraints, only if there is severe and imminent danger to clients and or staff.

The New Freedom Commission on Mental Health (2003) advised the mental health profession to adopt the two guiding principles of recovery as a possibility for all individuals within the mental-health system. The first principle ensures that treatment is consumer and family focused to allow for meaningful treatment choices. Rather than strictly managing symptoms, the second principle emphasizes the individual's ability to cope with challenges and facilitating recovery. The New Freedom Commission reported that when an individual is under the control of someone or something, such as through restraints, he or she does not have the ability to develop or implement self-management techniques. The New Freedom Commission (2003) directed those administering restraints to utilize them only as a last resort safety measure.

These recovery principles resulted in a new culture and standard. The culture encourages a system of particular values and beliefs in the mental-health field. Recovery is predicated upon the interaction of characteristics within the individual, such as hope, characteristics within the environment such as opportunities, and the exchange between the individual and environment, such as choice (Oken, Craig, Ridgway, Ralph, & Cook, 2007). This multidimensional process for the individual is linked to the culture of the organization, staff, and available resources.

Guidelines published by the mental-health and education sectors focus on the culture of recovery, as well as on training programs to help reduce restraints and on the therapeutic environment. In October 2004, SAMHSA awarded eight State Incentive Grants to adopt and support best practices for reducing and ultimately eliminating the use

of seclusion and restraint in settings that served individuals with mental illnesses. During that time, SAMHSA supported and continues to support training assistance programs for organizations. One of the NASMHPD initiatives is the National Technical Assistance Center for State Mental Health Planning. The training is available for executive senior-level facility managers and state mental health agency members. The training presents literature on what helps and hinders organizations in developing and facilitating mental-health recovery. Another important initiative, led by SAMHSA, is a consumer-centered staff-training manual. This manual is being piloted in two states with the intent to disperse it across the United States as a training curriculum to aid organizations in the development of recovery focused on positive alternatives to restraints (Curie, 2005).

NASMHPD (2005) supported the culture of recovery and developed six core strategies for reducing restraints. The Pennsylvania Department of Public Welfare (2009) then adopted the six core strategies for reducing restraints in their recovery policy. The six strategies for reducing restraints outlined include leadership support for organizational change, use of data to inform practice, staff development and training in restraint use and alternative interventions, the use of restraint reduction tools, including the child and family in the organizational change, and debriefing techniques.

The outcomes from the six core strategies published by NASMHPD have been positive throughout the United States in community based and psychiatric hospital settings (LeBel et al., 2010). Through grants from SAMHSA awarded to nine community-based mental-health facilities, from SAMHSA, data supports the reduction and eventual elimination of restraint use from those that have adopted the core strategies. LeBel et al. (2010) reported that all nine of the residential locations reduced restraint use

after the implementation of the six core strategies. Additionally, the most successful site restraint use fell 49% after implementing the core strategies (Child Welfare League of America, 2004). Overall, there were varying degrees of effectiveness across the locations because some agencies focused on reducing more intensive procedures first, such as mechanical restraints and seclusions, before focusing on physical restraints. Variability among sites also occur because several sites had been targeting restraint reduction techniques prior to the baseline time period and had downward trends in restraint use prior to the official start of the treatment condition (CWLA, 2004).

The SAMHSA Best Practice in Behavior Support and Intervention Project was a 3-year implementation grant that began in the first year with the coordinating center providing 300 days of technical assistance and support for the identified sites' training programs. Within the first year, the coordinating center and implementation site developed an evaluation system to measure the effects of trauma-informed training interventions within each site. The outcome evaluation methodology was standardized throughout implementation sites and consisted of initial assessments of policies and procedures, a measure of organizational climate, measures around family centeredness, and specified data around the frequency, intensity, and durations of restraint use that were submitted on a quarterly basis. The second year of the grant focused on refining training programs to continue to integrate the trainings throughout the organizations. The last year of the implementation of the grant focused on continued technical assistance and disseminating the best practice approaches and project outcomes of the study.

The results of the project were promising and gave support for the use of core strategies. For example, the Grafton School in Virginia, after implementing the core

strategies on one campus, decided to create an agency-wide initiative to reduce restraints across their four campuses. Each campus joined the leadership support and bonus program. Each campus built its own program-specific action plan, which focused on the six core strategies. Since its implementation in 2004, the Grafton School has reduced the rate of restraint usage by 99% and staff injury rates by 83% (Sanders, 2009). Azeem, Ajula, Rammerth, Binsfeld, and Jones (2011) assessed the effectiveness of the six core guidelines to aid with reducing restraints within a psychiatric hospital. Results indicated that within 6 months of the implementation of the NASMHPD strategy, restraints in the hospital reduced from 22 to 11.

One of the models outlined and supported in LeBel et al. (2010) work is Sandra Bloom's sanctuary model. The group discussed the implementation process and outcomes that the Andrus Center for Children in New York experienced after implementing the model. The Andrus Center for Children has many mental-health programs for children, including residential treatment, school-based services, and therapeutic services. The Sanctuary Model yielded successful outcomes by reducing restraints and increasing the therapeutic value of the environment for individuals and staff at the facility. The Andrus Center reported a reduction in its use of restraints by 93% over a 10-year period, reduction in restraint duration by 83%, and reduction in staff turnover by 50%. The Sanctuary Model is one of many models and programs that focus on decreasing restraints and improving the therapeutic environment for individuals and staff. (For further discussion of other models see Couvillon, Peterson, Ryan, Scheuermann, & Stegall, 2010; LeBel et al., 2010; NASMHPD, 2009).

The Sanctuary Model

Origin and History. The Sanctuary Model is a promising practice that is predicated on trauma-informed care, requiring an organization to change the culture within the agency to provide an environment that allows healing from psychological or social traumatic experiences (Bloom, 1994). The Sanctuary Model emphasizes an injury and recovery versus a sickness and stabilization model of treatment. The Sanctuary Model is based on guiding principles and commitments relating to specific “tools” or interventions that reinforce a positive therapeutic culture when practiced within an agency. The model fosters a nonviolent therapeutic culture with a foundation based on attachment, containment, communication, involvement, and empowerment (Jennings, 2004; Yanosy et al., 2009).

The Sanctuary Model was initially utilized in a short-term psychiatric inpatient acute-care facility for adults (Bloom, 1994). One of the first adult inpatient hospitals to implement the Sanctuary Model, Salem Hospital eliminated the use of mechanical restraints post implementation of the model (Jennings, 2004). The Sanctuary Model was then implemented in a long-term adult psychiatric facility (Bloom, 1994). More recently, the Sanctuary Model has been employed in a variety of settings for adults and children. These include domestic-violence shelters, group homes, schools, outpatient settings, substance abuse settings, and parenting programs (Banks & Vargus, 2009; Bloom, 2005; Jennings, 2004; Yanosy et al., 2009).

In 2005, Sandra Bloom and the Andrus Center for Children partnered to develop the Sanctuary Institute, a training and technical assistance program for the Sanctuary Model. The Sanctuary Institute was designed to help organizations implement the model

and become nationally certified. The Institute created a manual to implement the model within organizations. The Sanctuary Institute selects organizations to implement the model and then trains staff to implement the model and certifies the organizations once positive outcomes are reached.

The Blueprint. The Sanctuary Model is considered a promising practice to a whole-systems approach to positive organizational change (Yanosy et al. 2009). The Sanctuary Model is not a step-by-step intervention treatment; rather, it is an outline for creating a trauma-informed and positive therapeutic culture for staff and individuals within a treatment program setting. Nevertheless, the model still delineates specific steps and guidelines to follow during its implementation. Since the Sanctuary Model is not a manualized treatment, organizations are encouraged to adapt and apply the model to their specific settings (Yanosy et al., 2009).

Two basic beliefs about human beings lay the foundation for the commitments of the Sanctuary Model. The first belief is that experiences shape people's behaviors and that adversity and resiliency are parts of human life. The second belief is to appreciate and take into account the experiences of another individual and how that individual may have changed based on these experiences. The second belief is built on trauma-informed care by asking, "What happened to you?" instead of "What's wrong with you?". This belief is grounded in trauma-informed theory and assumes an understanding that all individuals are shaped by experiences. These two beliefs stand as the basic foundation of the Sanctuary Model. There are specific commitments and interventions to exemplify these beliefs. These interventions consist of the seven commitments; the S.E.L.F model, which stands for safety, emotion management, loss, and future; and the Sanctuary toolkit

that will be outlined below (Yanosy, Harrison, & Bloom, 2009).

Philosophical Underpinnings. The seven commitments are the foundation of the sanctuary model, and staff at all levels must agree to the commitments. The philosophy includes being committed to nonviolence, emotional intelligence, social learning, democracy, open communication, social responsibility, and growth and change. The seven commitments are at the forefront of the model's implementation process. The commitments are the standards by which staff and clients agree to operate. These seven commitments are the common values that guide an organization to create Sanctuary (Yanosy et al., 2009).

The Sanctuary Model is a whole organizational and system wide process of change. Administrators, supervisory staff, and direct-care staff work together on the seven commitments and use a common language in the therapeutic community, S.E.L.F. The components of S.E.L.F allow everyone within an organization to structure his or her conversations surrounding the core issues he or she experiences in a simplified and unified manner (Yanosy et al., 2009).

The Sanctuary toolkit consists of the practical tools used to promote the values of the model. The toolkit lists the steps and interventions used to operationalize and bring to life the values of the model. The tools in the toolkit are community meetings, Professional Quality of Life Scale, safety plans, psychoeducation groups, treatment-planning conferences, team meetings, red-flag meetings, and self-care plans. The interventions outlined in the toolkit are individually implemented within each agency in the most effective way deemed by that agency.

Community meetings are the primary intervention implemented in the Sanctuary

Model. The purpose of community meetings is to bring people together to build a group commitment towards group and individual goals and to build a healthy routine within the community at the beginning of every day. Community meetings are considered a short check-in with the goal of identifying individual concerns and connecting individuals with supports within the group. Community meetings can include staff, clients, or both. Three questions are asked during community meetings that provide the basic structure. The first question is, “How are you feeling?”. This question helps the group recognize tensions or needs among individual members in the group. The second question is “What is your goal for the day?”. This question helps to maintain the group focus toward the future. The third question asked during the community meeting is, “Who will you ask for help?”. The goal of this question is to build relationships within the group and to help with achieving individual daily goals. In addition, other questions and adaptations can be used during the community meetings that are relevant to the specific setting and group. By maintaining structure within the community meetings, participants are able to build a daily routine and a healthy outlet to discuss concerns, as well as to set individual goals (Yanosy et al., 2009).

The second intervention used in the Sanctuary Model is the Professional Quality of Life Scale (ProQoL Scale). The ProQoL is a measure of compassion, fatigue, and burnout, as well as satisfaction and secondary trauma, for staff. This tool gauges individuals’ experiences with regard to work and the impact of trauma. Once the assessment is individually administered, the facilitator leads a discussion based on the scale's individual and the group outcomes. This allows individuals within an organization to gauge the effects of trauma on the workplace and of experiences that have

impacted staff. The purpose is to allow for an open dialogue within the group setting based on the results (Yanosy et al., 2009).

Safety plans are the third tool within the toolkit of the sanctuary model. A safety plan as defined by the Sanctuary Institute is a visual and concrete way of managing emotional stress. A safety plan is a written plan that each individual carries as a reminder of strategies to reduce stress. Within the sanctuary model, it is important to facilitate a discussion with clients pertaining to the situations or emotions that are the most difficult to manage. This discussion enables the team to individualize and address core emotions and situations in which the client feels most vulnerable. Four domains need to be addressed in the plan. First, physical safety ensures physical bodies are safe. Second, psychological safety provides the individual the ability to remain safe within the self (i.e., not having suicidal thoughts or negative self-talk). Third, social safety occurs when an individual remains safe and is not teased or shamed by others. Lastly, moral safety provides guidelines for individuals to make prosocial decisions and not withhold information that may impact others in a negative way. When these domains are addressed, a list of activities is developed to assist in maintaining safety from harmful activities. Safety plans should include activities for fostering individual and social support, alone and with others, and for decreasing and managing emotional stress (Yanosy et al., 2009).

The next tool within the Sanctuary toolkit is the psychoeducation group. The Sanctuary Institute believes the goal of the psychoeducation group is to aid clients in understanding how experiences impact their current lives. The psychoeducation content is divided into six areas. The groups focus on several content areas, including trauma

theory, S.E.L.F., safety, emotional management, loss, and the future. The psychoeducation content areas include the principles of S.E.L.F, allowing individuals to learn and demonstrate commitment to social learning, emotional intelligence, social responsibility, and group change. The Sanctuary Institute provides in the training manual the materials and curriculum for each of the six content areas in the training manual (Yanosy et al., 2009).

Treatment-plan conferences (TPC) are the next tool discussed within the Sanctuary toolkit. The TPC are organized in accordance with the S.E.L.F for assurance of a common language. The TPC are facilitated in a nonhierarchical manner. All team members encompassing clients, families, and staff have an equal voice. The TPC are a means to measure client progress and growth in congruence with organizational standards. A series of questions developed by the Sanctuary Institute is used during the TPC, which follow each of the four domains of S.E.L.F. By following a nonhierarchical system, S.E.L.F domains, and solution-focused ideals, the TPC allow staff, clients, and family members to contribute to the growth and future planning for the individual's treatment (Yanosy et al., 2009).

The next intervention is the use of team meetings. Team meetings always begin with a community meeting, followed by a discussion of the clients, new ideas, and staff or community issues. Team meetings have a specified goal and are held only when called by a family or team member, such as a teacher, parent, support staff, or administrator. When facilitating team meetings, a clear agenda is set; the facilitator asks for discussion items in advance and solicits and accepts feedback. Encouraging participation within the team and delegating responsibilities for the agenda items are

critical. By delegating responsibilities, this allows for full participation and a nonhierarchical approach (Yanosy et al., 2009).

Red-flag meetings are another support within the Sanctuary toolkit. Red-flag meetings are short meetings to address critical incidents. Red-flag meetings are internal meetings attended by administrators, direct staff, and support staff involved in the incident. The focus of red-flag meetings is to develop solutions, rather than to describe problems. The Sanctuary Institute devised red-flag meetings with the premise of allowing people to come together to discuss innovative solutions to a problem. The main reasons to call a red-flag meeting include the use of physical restraints; increased aggression; injury; and client, staff or family complaints. At the end of the red-flag meeting, a plan is developed that addresses the incident and the facilitator should discuss how the plan would be accomplished (Yanosy et al., 2009).

The last tool in the Sanctuary toolkit is self-care plans. Self-care plans comprehensively outline specific activities that the individual believes will be beneficial to remain physically and mentally healthy if practiced regularly. Self-care plans are proactive interventions practiced regularly rather than just in the moment of distress. Self-care plans should include personal, professional, organizational, and social areas of a person's life. Self-care plans also include individualized short and long-term health and wellness goals (Yanosy et al., 2009).

Implementation and Evaluation. The Sanctuary Institute has established participation standards for any agency interested in becoming a site that implements the Sanctuary Model. The Sanctuary Institute evaluates organizations on adherence to the model. During the evaluation process, a consultant from the Sanctuary Institute

interviews staff and clients. The evaluator tours the organization; observes; and reviews its policies, procedures, and clinical documentation (Yanosy et al., 2009). Depending on the size of the organization, implementation can extend from 1 to 3 years in order to address all of the Sanctuary Standards. The Sanctuary Standards are subcomponents within the seven commitments and S.E.L.F. There are 36 standards within the categories of safety, emotion management, loss, future, nonviolence, emotional intelligence, social learning, democracy, open communication, social responsibility, growth, and change.

When an organization and the consultant from the Sanctuary Institute deem it time for evaluation, the evaluator assesses the organization to determine if the standards required for the Sanctuary certification have been met. By becoming certified in the model, the organization has met the standards to provide services in a trauma-sensitive environment for individuals and a positive environment for staff. The Sanctuary Institute certifies organizations that ensure fidelity to the Sanctuary Model. The Sanctuary Institute states that certified agencies have yielded the following results: improved treatment outcomes; enhanced staff communication; reductions in violence, such as restraint use and injuries; increased job satisfaction; and improvements in the areas of nonviolence, increased emotional intelligence, social learning, and open communication (Yanosy et al., 2009).

Sanctuary Model Research. Atlantic County, New Jersey, was one of the initial school-based Sanctuary Model implementation sites posted on the Sanctuary Model website. In 2002, the New Jersey Department of Education (NJDE) funded the project called Sanctuary in Schools under the Safe Schools and Communities Violence Prevention and Response Pilot Plan Initiative and through the Richard Stockton College

of New Jersey. The proposals called for promising practices targeting school violence that involved the individual, school, family, and community. The NJDE chose the Sanctuary Model because it was the only model out of 177 proposals that included all of the elements that the NJDE attempted to address within the safe school and community initiative.

At this time, a peer-reviewed article has not been submitted describing the results of the project conducted in the Atlantic County schools. However, two documents from the Sanctuary Model website outline the implementation process of the model and Sandra Bloom's qualitative analysis of the results. In the brief review of Sandra Bloom's analysis, she discusses the aims of the study and factors that impacted the implementation process. In analyzing the Sanctuary Model in the school setting, variables that seemed to affect the implementation process were conflicts in the basic assumptions of the definition of safety within the schools, the hierarchical nature of schools versus the democratic processes the Sanctuary Model is built upon, the faculty not wanting to "give up" control, and faculty not feeling comfortable engaging in the democratic process in the classroom. Sandra Bloom concluded that building Sanctuary in schools is a long-term prevention method that can begin only after basic physical safety concerns have been addressed. The Atlantic County schools had many concerns regarding physical safety and until these concerns could be addressed adults and children would have difficulty focusing on psychological and social safety (Bloom, 2002). This initial review of the implementation process of the sanctuary model was written prior to the development of the Sanctuary Institute. The Sanctuary Institute now evaluates sites on inclusion criteria before agreeing to train staff in the model and provides supervision for other school-

based settings (Bloom, 2002).

The Pace School began implementing the Sanctuary Model in 2005 and became a certified site in 2008. To date, there are no published peer-reviewed articles regarding the implementation process or outcomes; however, the Sanctuary Institute reported the school's implementation results. Reported outcomes from the Pace School implementation of the Sanctuary Model were a reduction in reported aggressive acts, improvements in attendance, improvements in academic performance on benchmarks, and a reduction in higher level of care. Barriers reported by the school were staff turnover, ongoing training requirements, the need for family and community involvement, staff resistance to change, and the amount of time needed to fully implement the model (Pace School, 2013). Similar outcomes and barriers have been reported in school and clinical settings.

By 2009, the sanctuary model had been implemented by approximately 100 organizations around the world, including juvenile-based organizations, residential facilities for children and adults, community-based organizations, and hospitals (Banks & Vargas, 2009; Yanosy et al., 2009). Organizations implementing the sanctuary model have changed from its original inpatient hospitalization population. Once the sanctuary model began to demonstrate positive outcomes, the model expanded to a variety of treatment setting such as domestic-violence shelters, outpatient facilities, drug and alcohol treatment centers, community-based programs, and schools that began to implement and publish baseline outcomes on the model (Azeem et al., 2011; Banks & Vargas, 2009; Bills & Bloom, 2000; Bloom, 2005; Rivard, Bloom, McCorkle, & Abramovitz, 2005; Jennings, 2004). Outcomes from sites implementing the Sanctuary

Model demonstrated reductions in violence as measured through critical incidents. Fewer staff/client injuries and fewer instances in the use of restraints occurred. Job satisfaction improved as measured by staff turnover and job satisfaction measures. Increased successful discharges were noted. Reduction in the rates of those discharged for a higher level of care and a more favorable environment as measured by reported sense of community and communication have resulted (Banks & Vargas, 2009).

In a preliminary study examining the outcomes of the Sanctuary Model in a residential treatment facility for children that utilized the Community Oriented Program Environment Scales-Revised (COPEs-R) to measure if there was an effect on the therapeutic environment and individual behavior measures, results indicated significant changes post implementation of the model (Rivard et al., 2005). A comparison group design was used to measure the impact of the Sanctuary Model on four residential units that were self-selected. There were three data points, baseline, 3 months, and 6 months, when the sanctuary model units were compared to the units in which the model was not being implemented. Results indicated that by the 6-month point, there was a statistically significant difference between the units where the sanctuary model was implemented and to the control units in the spontaneity, autonomy, personal problem orientation, safety, and total score scales on the COPEs-R measure at the ($p < .05$) level. Results indicated that the longer the model was implemented, the more impact that the sanctuary model had on the therapeutic environment measured by the staff.

Banks and Vargas (2009) published results from five public schools that piloted the Sanctuary Model in North Carolina and New York. The schools reported a decrease in restraint use, critical incidents, and staff turnover as well as improved treatment

outcomes. According to the report, 1 year into the implementation process, there was a 6 to 88% decrease in restraint use in three of the schools. Three schools had a reduction in restraint use greater than 80%. Results noted that critical incidents decreased in one organization by 30% from baseline in Year 1. Within 2 years, schools certified in Sanctuary demonstrated a 41% reduction in the number of children requiring psychiatric hospitalization, as well as a 25% reduction in the number of days spent inpatient, if a child was hospitalized. Of the five sites certified in Sanctuary Model, 100% reported improvements in the rate of staff turnover during a 2-year period. The greatest decrease in staff turnover was from 46% at baseline to 24% within 2 years of implementation of the model. Overall, job satisfaction showed improvement within the organizations implementing the sanctuary model. Generally, school and organizational environments strengthened in the areas of program clarity, open communication, safety, and a sense of responsibility. There was variability in outcomes among these agencies; however, the researchers did not discuss any differences between the sites. Perhaps there was variability among the staff's background or experiences, differences in the demographic areas of the schools, or differences among the trends in the indicators measured across organizations prior to implementing the sanctuary model. Limited information was given concerning the methodology and data collection during the given time frames. Continued initial studies, such as this, are important to further evaluate effectiveness and considerations when implementing the sanctuary model in school.

Although promising initial results do exist, there is a dearth of studies evaluating the short-term implementation process of Sanctuary, and even fewer researchers evaluating the results of short-term implementation in schools (Banks & Vargas, 2009;

Madsen et al., 2003; Rivard et al., 2005). There is a need to continue to expand the evaluation of the Sanctuary Model in various approved sites, as well as to quantitatively measure the outcomes of the model using standardized inferential statistics. The many published outcomes studies on the Sanctuary Model have led to the model becoming an evidence-supported treatment and promising practice; however, currently research evaluation projects underway may support the sanctuary model becoming an evidence-based treatment (The National Child Traumatic Stress Network, 2008).

Choosing the Sanctuary Model. A multitude of restraint reduction intervention programs as well as trauma-informed care models have been outlined by SAMSHA. One of the major factors that played a part in the current research site choosing the sanctuary model is the model's foundation in trauma-informed care for staff and patients that allows organizations to develop a nonviolent culture in a collaborative way. The sanctuary model has outlined outcomes, such as reducing restraint use and increasing staff retention and morale. SAMHSA outlined seven other programs and out of the seven, five of the programs are exclusively patient-based, trauma-informed care rather than a collaborative cultural shift for staff and patients. The other two programs were created for staff and patients but specialize in targeted groups. Specifically, the addiction and trauma recovery integration model targets issues linked to the experience of both trauma and addiction and the Essence of Being Real curriculum targets adult patients and staff and is not intended for children (Substance Abuse and Mental Health Services Administration, n.d.a). Administrators at the current research site attempted to target both children and staff utilizing a trauma-informed model that could help decrease restraint use, strengthen the therapeutic environment for staff and students, and increase job satisfaction among

the staff. The Sanctuary Model was the trauma-informed intervention model that met the site's specifications.

As promising as the initial research results on the sanctuary model have been, there are criticisms of the model. Similar to other treatment approaches and philosophies, both the positive and negative aspects of the model must be recognized to account for possible variability in results across organizations implementing the sanctuary model. These critiques of the sanctuary model are currently reported by the National Child Traumatic Stress Network (NCTSN) (2008). The first criticism reported by the NCTSN (2008) is the high cost of the training and the requirement of the organizations to fund the training and supervision during the implementation period. The second criticism of the sanctuary model reported is the length of the implementation process. The full implementation of the model can stretch from 2 to 5 years, depending on the organization is size and on obstacles of implementing the principles of the model. The variability in the length of the implementation of the sanctuary model impacts the cost and resources needed throughout the process. Lastly, one of the qualitative advantages, which can also be viewed as a criticism reported by the NCTSN is the ability to adapt the model across many different populations and settings because the model is principle based versus a manualized approach. The implementation of the principle-based model can be ambiguous because organizations are to adapt and become innovators of the model in their specific settings. Acknowledging potential obstacles is critical when implementing any model so that organizations can make an informed decision of the viability of different options.

In 2011, the current evaluation site became an implementation site for the

Sanctuary Model through the Sanctuary Institute. This site is a private, non-profit, community behavioral health care organization delivering emotional-support, school-based services; outpatient therapy; and community-based behavioral health care. The site chose to implement the sanctuary model over other trauma-informed models because of the supporting evidence and promising practice status that the sanctuary model has attained for staff and client outcomes. Specifically, the preliminary research studies have yielded such results as creating a trauma-informed culture within organizations, a nonviolent therapeutic environment, and increased staff job satisfaction. In both mental-health and educational settings, need to support children and staff in a least restrictive, positive supportive environment continues (Banks & Vargas, 2009). The current study assesses the short-term outcomes of the Sanctuary Model, implemented in a private educational setting.

Chapter 3: Hypotheses

With consideration to the research on the Sanctuary Model, the following are the hypotheses for the current study measuring the outcomes during the first year of implementation of the Sanctuary.

Hypotheses

- There will be a significant reduction in the use of restraints in the Elementary Emotional Support (EES) program after a 1-year implementation of the Sanctuary Model.
- The following variables within the COPES-R scale (involvement, support, spontaneity, autonomy, practical orientation, personal-problem orientation, anger and aggression, order and organization, program clarity, and staff control) will significantly improve following the implementation of the Sanctuary Model as evaluated by the staff.
- Job satisfaction among the staff from pre to post-implementation of the model will increase in the EES program following a 1-year implementation of the Sanctuary Model as measured by the job satisfaction survey.

Chapter 4: Method

Design

The design of this project was a pre to post repeated measures outcome study. The research assessed for changes within the EES program at the site during the first year of implementation of the Sanctuary Model. The EES program is located in a suburban area within the mid-Atlantic region.

Participants

Participants were students, teachers, and teachers' aides in the EES program at the site. All students (2010-2011 $n = 39$; 2011-2012 $n = 31$), teachers ($n = 5$ for 2010-2011 and 2011-2012), teachers' aides ($n = 5$ for 2010-2011 and 2011-2012), and a licensed clinical social worker ($n = 1$ for 2010-2011 and 2011-2012) participated in the implementation and outcome measurement of the Sanctuary Model. The school provides education for kindergarten through eighth-grade students with emotional-support needs. The teachers had bachelor degrees with a special-education certification. The teachers' aides had bachelor's degrees in a mental-health-related field. Additionally, there was a total of 39 students in the 2010-2011 school year and 31 students in the 2011-2012 school year.

Inclusion Criteria. All students and teaching staff at the site during the 2010-2011 and 2011-2012 school years participated in the implementation of the Sanctuary Model. Implementation of the model was agency wide and guided by the Sanctuary Institute, the site's internal Sanctuary committee, and administrative staff.

Recruitment. The EES program is located in a suburban area within the mid-Atlantic region. Local area school districts refer children to the site when their academic

needs are not being met as a result of behavioral concerns. All children and staff within this organization were automatically recruited for this study.

Measures

Community Oriented Program Environment Scale-R (COPES-R); (Moos, 2009). The COPES-R scale is a 100-item, self-report measure consisting of three dimensions and 10 subscales. It measures staff perception of the treatment environment. Individuals answer true/false questions within the domains of relationships, personal growth, and system maintenance as related to their place of work. In addition, 10 subscales include: involvement, support, spontaneity, autonomy, practical orientation, personal-problem orientation, anger and aggression, order and organization, program clarity, and staff control. For purposes of this study, the COPES-R was used to measure change within the therapeutic environment before and throughout the implementation of the Sanctuary Model.

The measure was originally devised in residential treatment facilities and inpatient hospitals. The COPES-R was adapted to meet the needs of the school environment. The COPES-R measure was slightly modified for a school setting by deleting two questions deemed irrelevant. Additionally, a few words were changed, such as “members” to “students” to help alleviate any confusion by the school staff during administration. Research supports the predictive, construct, concurrent validity ($r = .83$) and test-retest reliability ($r = .81$) with the COPES in residential treatment facilities, therapeutic communities for substance dependency, psychiatric hospitals, and shelter communities (Rivard et al., 2005).

Job Satisfaction. Job satisfaction was measured by using a 17-item, self-report electronic survey. Respondents answer questions that were constructed by an independent research group, WorkPlace Dynamics (2013), using a 5-point rating scale from *strongly disagree* (1) to *strongly agree* (5). The survey takes approximately 5 minutes to complete and is anonymous. The survey contains six subscales, including direction of the agency, execution within the agency, sense of career within the site, conditions within the site, relationship with management, and pay and benefits. The psychometric information for the survey was unavailable at the time of the study. The school staff was given the survey in 2011 and was re-administered the survey in 2012. The results were analyzed for changes in satisfaction from pre to post-implementation of the Sanctuary Model after 1 year of implementation.

Physical Restraints. Frequency of physical restraints was measured by occurrence rate and collected on a monthly basis. The site defines physical restraints as staff members having to physically hold a child and control the child's movements. Furthermore, the site reports any change in position or location within the same incident as additional restraints. The site has a 10-minute safety policy within which the staff are required to release the restraint; if the student continues to need to be restrained, the staff will then reestablish the restraint. For purposes of this study, each restraint or repositioning was counted (i.e., if a child required multiple restraints within the incident, each was counted). The restraint is reported on an incident report within 24 hours of the incident and given to the division director and quality improvement director. The monthly and yearly numbers of total physical restraints in the 2011-2012 school year were compared to the number of restraints in the 2010-2011 school year.

Procedure

The site's administration subscribed to the mission and vision of the Sanctuary Model in order to provide quality, innovative, and evidence-guided programming. The Sanctuary Model was chosen by the administration because of the risk of staff burnout and secondary trauma the staff experience as a result of increased levels of behavioral and emotional concerns within the students in the school. This concern was critical for administration, as burnout and secondary trauma had resulted in poor service delivery, decreased job satisfaction, and increased physical and emotional stressors. The Sanctuary Model appeared to provide empirical support in targeting goals of the organization through reported reduction in restraints, reported increased positive factors within the therapeutic environment, and increased job satisfaction within the program.

A member of the Sanctuary Network team evaluated each program of the site. Policies and procedures within the agency were scrutinized prior to allowing the site to move forward in training. Once the site was selected to begin training in the sanctuary model, a core team of five individuals was chosen. The implementation of the sanctuary model began with these core team members. These individuals participated in a 5-day training program with the Sanctuary Institute. After the core team was trained, a larger Sanctuary committee was created from staff volunteers throughout the agency from various departments and job descriptions. Following the creation of the committee, members from the Sanctuary Network came to the site to educate and train the full committee in the model. A booster session was provided for the core team who had already undergone the training to provide an opportunity for questions and to further facilitate implementation.

The implementation process began with monthly Sanctuary team meetings for the entire group, as well as core team meetings. In late November 2011, the Sanctuary committee began meeting in order to learn the seven commitments and to formulate a plan integrating Sanctuary Model ideals within the confines of the agency. The EES program began to implement community meetings daily in January 2012 to build a commitment to group and individual goals.

Since the emotional-support school was established, the staff and quality improvement committee have been monitoring restraints. After each incident when a restraint is implemented, the staff member involved completes an incident report within 24 hours. The incident report is given to the division director of educational services and then the director of quality improvement. The data is totaled and graphed monthly for the agency and reported to the Performance Improvement Committee.

The COPES-R and a measure of job satisfaction were administered to the staff for baseline measurements prior to the Sanctuary training and implementation. The COPES-R was re-administered on a somewhat quarterly basis at the site's staff in-services in February and May 2012 and October 2012. The job satisfaction measure was administered in September 2011 and 2012. Restraints were measured and analyzed on a monthly basis.

Statistical Analysis

- 1. Hypothesis: There will be a significant reduction in the use of restraints in the EES program after a 1-year implementation of the Sanctuary Model.
 - Restraints were measured through a frequency count for the 2010-2011 school year prior to implementation of the Sanctuary Model and compared

to the number of restraints in the 2011-2012 school year during Sanctuary Model implementation. A *t*-test statistic was used to analyze the difference in the frequency in restraints from the 2010-2011 school year compared to the 2011-2012 school year.

- For each month of the 2010-2011 school year, the total number of restraints was compared to the corresponding month of the 2011-2012 school year (e.g., February 2011 was compared to February 2012).
- 2. Hypothesis: The following variables within the COPES-R scale (involvement, support, spontaneity, autonomy, practical orientation, personal-problem orientation, anger and aggression, order and organization, program clarity, and staff control) will significantly improve following the implementation of the Sanctuary Model as evaluated by the staff.
 - The average standard scores of each domain reported by the staff were compared to the standard scores of the normative sample published by Moos (2009).
- 3. Hypothesis: Job satisfaction among the staff from pre - post implementation of the model will increase in the EES program following a 1-year implementation of the Sanctuary Model as measured by the job satisfaction survey.
 - Job satisfaction was measured among staff from pre - post implementation of the Sanctuary Model. Average job satisfaction scores were reviewed from the 2011 and 2012 job satisfaction surveys.

Chapter 5: Results

The first hypothesis was analyzed using a paired-samples t-test to compare the number of restraints used prior to introducing the Sanctuary Model in the 2010-2011 school year and post implementation of the Sanctuary Model in the 2011-2012 school year. As outlined in Table 1, though the number of restraints decreased slightly, there was no significant difference in the number of restraints employed in the 2010-2011 school year ($M = 116$, $SD = 48.19$) and the 2011-2012 school year ($M = 113$, $SD = 58.36$); $t(9) = .098$, $p = .924$. Further, Cohen's effect size value ($d = .05$) suggested a small effect size. One should note that within every month, relatively few children were restrained and the majority of the restraints were accounted for by one to three students each month. This trend is similar to the findings reported by Allen, McDonald, Dunn, and Doyle (1997) in which one individual accounted for the majority (37- 50%) of restraints across a 2-year period.

In order to control for outlier effects, individuals accounting for 30% or more of the total restraints per month were removed from the calculations. The paired-samples t-test was conducted in order to compare the number of restraints used prior to introducing the Sanctuary Model in the 2010-2011 school year to post implementation during the 2011-2012 school year. As noted in Table 2 there was no significant difference in the number of restraints used in the 2010-2011 school year ($M = 55.5$, $SD = 39.68$) and the 2011-2012 school year ($M = 55$, $SD = 30.94$); $t(9) = .040$, $p = .969$, even after removing the individuals who were frequently restrained. Further, Cohen's effect size value ($d = .01$) suggested low practical significance.

Table 1

Summary of Findings: T-Test Total Restraints By Year

Year	<i>N</i>	Mean	Standard deviation	<i>t</i> (9)	<i>p</i>	Cohen's <i>d</i>
2010-2011	10	116	48.19	0.098	0.924	0.05
2011-2012	10	113	58.36			

Note: Frequency of restraints from pre - post implementation of the Sanctuary Model

Table 2

Summary of Findings: T-Test Total Restraints By Year with Outliers Removed

Year	<i>N</i>	Mean	Standard deviation	<i>t</i> (9)	<i>p</i>	Cohen's <i>d</i>
2010-2011	10	55.5	39.68	0.04	0.969	0.01
2011-2012	10	55	30.94			

Note: Frequency of restraints with outliers removed from pre - post implementation of the Sanctuary Model

Overall in the 2011-2012 school year, there was a reduction in the frequency of restraints in seven of the 10 months (359 fewer restraints during these months) and an increase in three of the 10 months, (278 more restraints during March, April, and May 2012) compared to the 2010-2011 school year. See Table 3 for a month-by-month comparison of restraint usage in the 2010-2011 and 2011-2012 school years. It is interesting to note that in March 2011 there were 51 restraints compared with 229 restraints reported in March 2012, an increase of 178 restraints. In addition, during March 2012, three students accounted for 71% of the total number of restraints. In further reviewing the noted large increase of restraints in March 2012, qualitative performance reports indicated that one student accounted for 98, or 43%, of the restraints and that

student had a medication change, requiring a reevaluation of the school placement and a subsequent placement in a partial hospitalization setting. Furthermore, in April 2011, 68 restraints were recorded compared with 157 restraints in April 2012. Additionally, in April 2012, a total of 11 students required restraints and four accounted for 75% of the month's restraints. In further qualitative review of April 2012, the student who required the greatest number of restraints had returned from an inpatient facility in March and in April had reported severe home stressors requiring an increased level of home-based services. These factors negatively impacted both the therapeutic environment for the other students and this student's individual behaviors.

In reviewing the data trends (Figure 1), there was an overall decreasing trend in 2010 from September to December and a peak in January 2011, after the return from the winter holiday break, and then a decreasing trend through March 2011. In the 2011-2012 school year, although there were fewer restraints overall than in the previous year, there was a less stable trend overall. There was a similar increase in trend in restraints in January 2012 compared to January 2011. As indicated previously, there was a significant peak in restraints in March 2012 and then a decreasing trend throughout the remainder of the school year. This review indicates variability in the trends between the 2 years; however, both years consistently showed an increase in restraint use in January following the winter break.

Table 3

The Number of Restraints in the 2010-2011 School Year Compared to the 2011-2012 School Year

Month	2010-2011	2011-2012	Difference
September	208	103	-105
October	168	121	-47
November	134	69	-65
December	124	72	-52
January	141	115	-26
February	88	82	-6
March	51	229	+178
April	68	157	+89
May	100	111	+11
June	82	24	-54

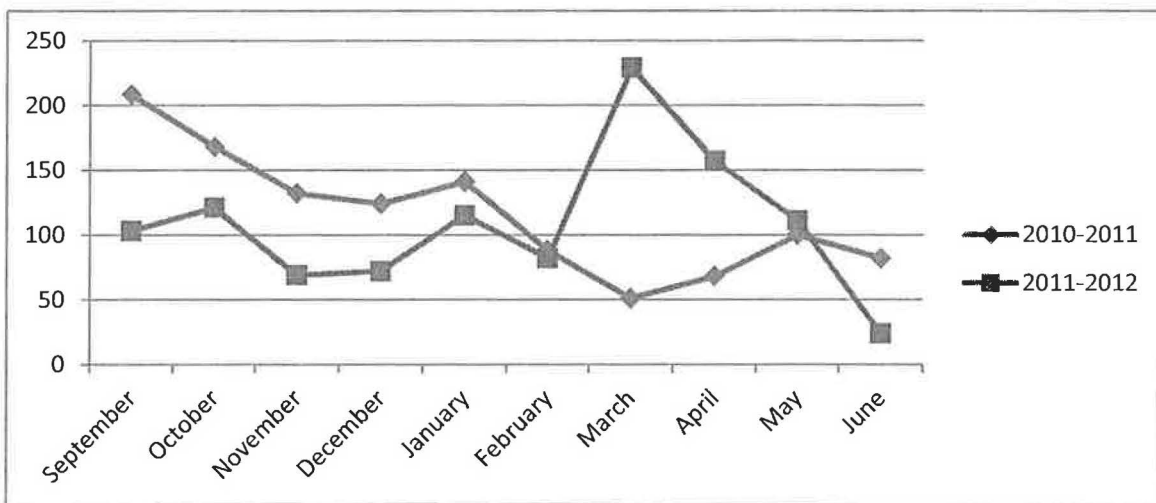


Figure 1. The number of restraints in 2010-2012. This figure illustrates the total restraints by month in the 2010-2011 and 2011-2012 school years.

To further evaluate restraint usage within the school, a paired-samples t-test was conducted to compare the number of children who were restrained during the 2010-2011 and 2011-2012 school years. Results, as noted in Table 4, indicated no significant

difference in the number of children restrained in the 2010-2011 school year ($M = 10.10$, $SD = 1.72$) and the 2011-2012 school year ($M = 10.20$, $SD = 2.34$); $t(9) = -.107$, $p = .917$.

Similar to the total number of restraints per month, three out of the ten months had an increased number of children restrained (February, March, and April 2012); (See Table 5). This increase was somewhat similar to the time of year that showed an increase in the number of restraints in 2012: March, April, and May.

Table 4

T-Test: Number of Children Restrained

Year	<i>N</i>	Mean	Standard deviation	<i>t</i> (9)	<i>p</i>	Cohen's <i>d</i>
2010-2011	10	10.1	1.72	-.107	0.917	0.04
2011-2012	10	10.2	2.34			

Table 5

Total Number of Children Restrained by Month

Month	2010-2011	2011-2012	Difference
September	13	10	-3
October	11	11	0
November	11	9	-2
December	12	10	-2
January	9	8	-1
February	9	11	+2
March	8	15	+7
April	9	11	+2
May	11	11	0
June	8	6	-2

The second hypothesis regarding the overall therapeutic environment could not be analyzed as planned using a MANOVA because of the small sample size (baseline $n = 10$; 2nd administration $n = 11$; 3rd administration $n = 11$; and 4th administration $n = 9$). To examine the impact that the Sanctuary Model had on the therapeutic environment from baseline through the fourth administration of the COPES-R, the average raw scores for each scale were compared to the staff normative sample means and standard deviations. The Moos (2009) normative sample consisted of 203 staff and 21 different children and adult community day programs. In October 2011, during the initial administration of the COPES-R, three of the ten domains (Involvement, Autonomy, and Program Clarity) (See Figures 2-4) were one standard deviation below Moos' (2009) normative staff sample, indicating potential weaknesses in these areas. In February 2012 during the second administration, only one domain was one standard deviation lower than the normative population: Order and Organization (see Figure 5). Similarly, in the third administration in May 2012, Order and Organization and Involvement were one standard deviation below the normative sample. Finally, on the fourth and final administration of the COPES-R in October 2012, the Involvement domain was one standard deviation lower when compared to the normative population. Overall, the number of discrepant therapeutic domains from the normative population decreased from three domains to one domain throughout the year. In addition, the Involvement domain was one standard deviation below the normative population in three of the four administrations (see Table 6).

Table 6
COPES-R Scores from Baseline to Fourth Administration

COPES-R Domain	Baseline	2 nd	3 rd	4 th	Norms	SD
Involvement	3.5	4.63	3.27	3.66	6.68	2.51
Support	8.7	7.72	6.72	7.77	7.54	2.01
Spontaneity	7.0	7.27	7.36	7	6.37	2.07
Autonomy	3.9	4.54	4.54	4.66	5.91	2.20
Practical orientation	5.6	5.72	5.72	6.22	6.27	2.11
Anger and aggression	7.4	7.63	6.9	7.33	6.12	2.34
Order and organization	5.3	4.18	3.27	4.55	6.5	2.00
Staff control	5.5	6.27	5.81	6.55	4.5	2.17

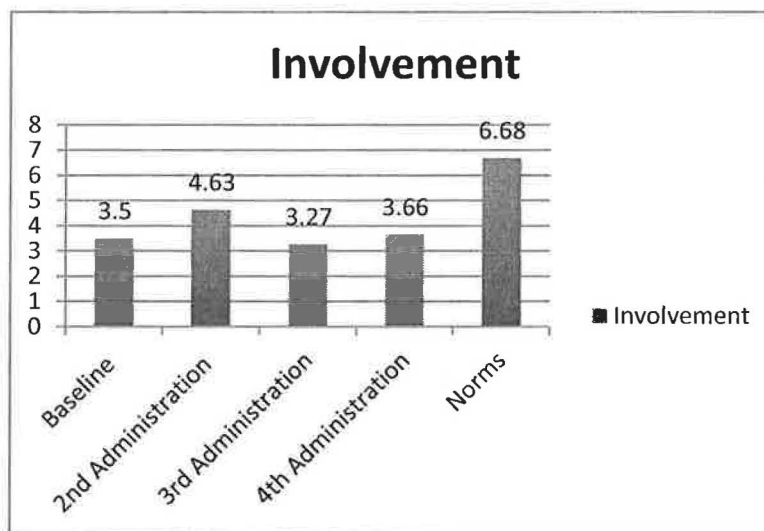


Figure 2. COPES-R: Involvement domain 2010-2012. This figure illustrates the average Involvement scores from each administration compared to the normative sample.

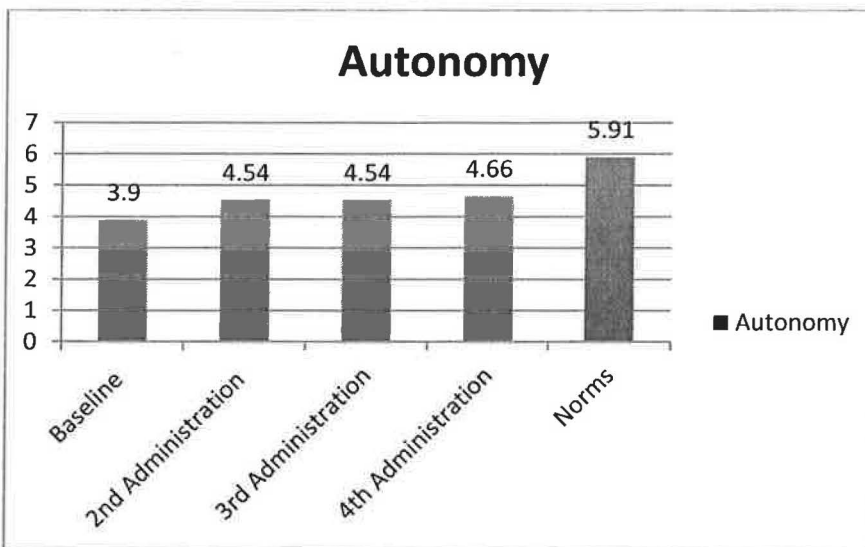


Figure 3. COPES-R: Autonomy domain 2010-2012. This figure illustrates the average Autonomy scores from each administration compared to the normative sample.

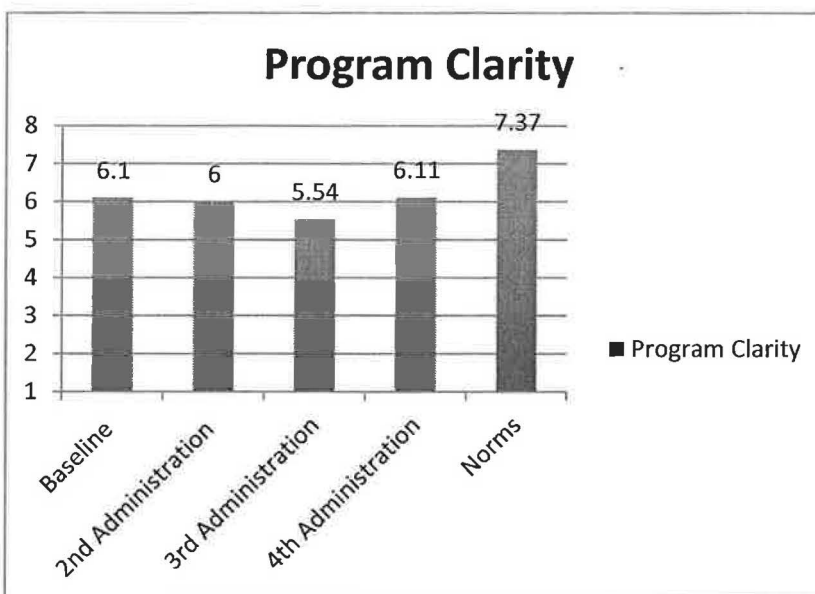


Figure 4. COPES-R: Program Clarity domain 2010-2012. This figure illustrates the average Program Clarity scores from each administration compared to the normative sample.

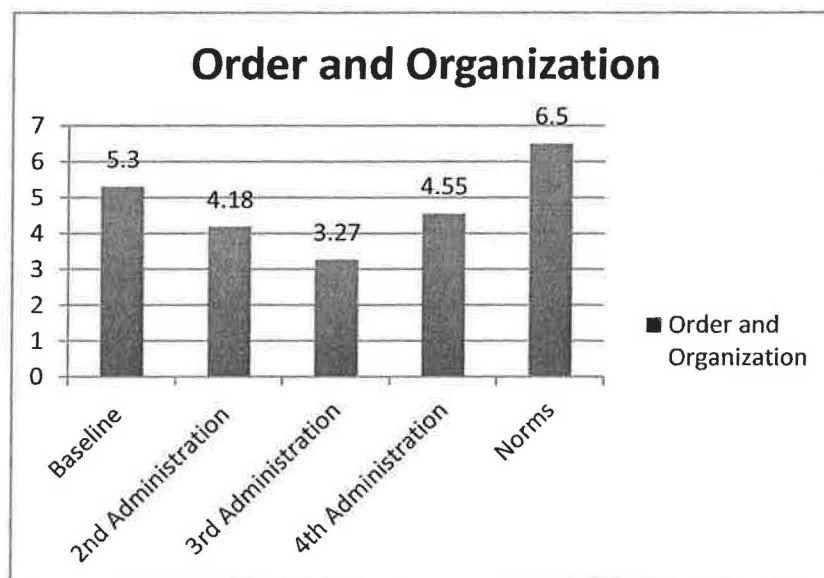


Figure 5. COPES-R: Order and Organization Domain 2010-2012. This figure illustrates the average Order and Organization scores from each administration compared to the normative sample.

To analyze the third hypothesis with regard to teachers' job satisfaction within the school environment, the average responses were reviewed from the 2011 and 2012 job satisfaction surveys (see Table 7 and Figure 6). Because access to average individual scores within the department was unavailable, a *t*-test could not be completed as planned. The responses show that in 2011, 10 teachers and teacher aides completed the survey. As a result of staff turnover within the school in 2012, eight faculty members participated. Overall, 14 of the 17 scales declined in satisfaction from 2011 to 2012. Of those 14 areas that resulted in decreased job satisfaction, an average discrepancy of .56 between the 2011 and 2012 school year, indicated decreased job satisfaction between the 2011 and 2012 school year, after implementing the Sanctuary Model. Furthermore, three areas yielded results with minimal increased or maintained satisfaction ratings using a 5-point scale in 2012, specifically, fair pay with the average 2011 rating 1.9 compared with 2012

at 2.88, less frustration within the environment with the 2011 rating 1.9 and 2012 rating 2.5, and confidence about the individual's future at the site with the average 2011 rating 3.7 compared to the 3.75 rating in 2012.

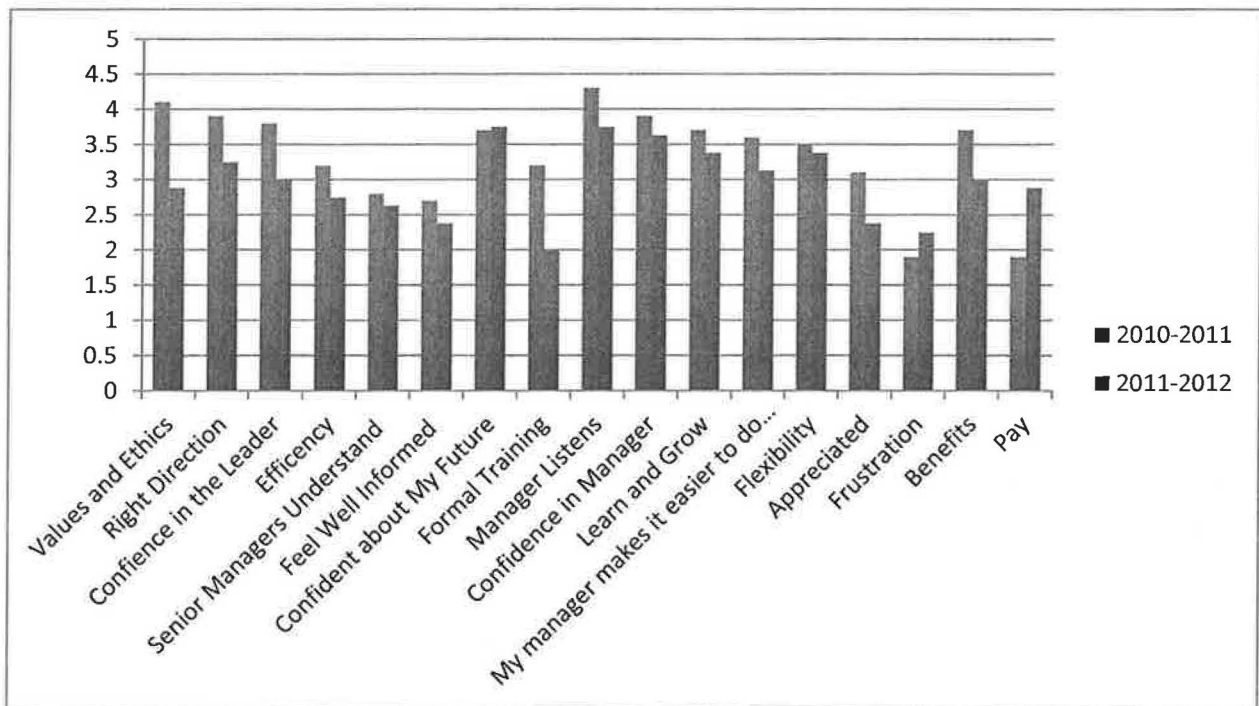


Figure 6. The average job satisfaction results 2010-2012. This figure illustrates the average job satisfaction scores in 2010-2011 and 2011-2012.

Table 7.
Average Job Satisfaction Score by Category

Category	2010-2011	2011-2012	Difference
Value and ethics	4.1	2.88	-1.22
Right direction	3.9	3.25	-.65
Confidence in the leader	3.8	3.00	-.8
Efficiency	3.2	2.75	-.45
Senior managers understand	2.8	2.63	-.17
Feels well informed	2.7	2.38	-.32
Confidence about my future	3.7	3.75	+.5
Formal training	3.2	2.00	-1.2
Manager listens	4.3	3.75	-.55
Confidence in manager	3.9	3.63	-.27
Learn and grow	3.7	3.38	-.32
My manager makes it easier to do my job well	3.6	3.13	-.47
Flexibility	3.5	3.38	-.12
Appreciated	3.1	2.38	-.72
Frustration	1.9	2.25	+.35
Benefits	3.7	3.00	-.7
Pay	1.9	2.88	+.98

Chapter 6: Discussion

Overview

The Sanctuary Model was implemented in an emotional support private school-based program specifically to evaluate outcomes relating to restraints, the therapeutic environment, and job satisfaction. Much of the published research on outcomes of the Sanctuary Model is related to the implementation process and long-term effects of its use (Banks & Vargas, 2009; Rivard et al., 2005). The Sanctuary Institute reports that the average implementation process within an organization can take 3 years (Yanosy, et al., 2009). The current outcome study assessed possible short-term effects of the Sanctuary Model and evaluated outcomes to provide recommendations for areas of focus for the remaining implementation process.

The first goal of the study was to compare the frequency of restraint use prior to the implementation of the Sanctuary Model with the frequency the first year of implementation. Results of this study suggest that the number of restraints in the 2011-2012 school year was not significantly lower than the number of restraints in the 2010-2011 school year. The results suggest that during the first year of implementation of the Sanctuary Model, improvements in decreasing the total number of restraints were minimal. However, 81 fewer restraints were used in the 2011-2012 school year when compared with the 2010-2011 school year. Also of importance to note is that in the 2011-2012 school year, seven of the 10 months yielded fewer restraints than in the previous year. These results are consistent with Banks and Vargas (2009), who published a three-year outcome study of the Sanctuary Model. Similarly, their study indicated only a slight

reduction in restraint use the first year; however, an even greater reduction was reported after 3 years.

One should also note that both restraint-related *t*-test results produced large standard deviations across both years. This result indicates a large variability in restraint use across each year. Furthermore, since a relatively small number of children contributed to the overall restraint use and high degree of variability across the years, mean data may not be an accurate way to measure between-group differences in restraint use.

As a result of the variability in restraint use noted by the large standard deviations across both years, considering the different ways restraint use can be measured to get a full clinical picture may be helpful. In previous studies analyzing restraint use, researchers have used such indicators as the duration of restraints and the number of staff and patient injuries that resulted from restraints (Allan, McDonald, Dunn, and Doyle, 1997; Rivard et al., 2005). Future research may consider analyzing different restraint-related indicators to provide more clinical information in the short-term implementation of the Sanctuary Model in regard to restraint use.

One should note that when evaluating the frequency of restraints, specific children, at times, accounted for 70% or more of the total. This consideration is important for agencies to track, plan, and target specific safety plans for these individuals through red-flag meetings, the development of safety plans, or even Positive Behavior Support Plans, which have been effective in reducing restraints (The Council for Children with Behavioral Disorders, 2009b; Yanosy et al., 2009). While the trend is not surprising and is consistent with the literature, several variables can account for

variability. Factors noted by NASMHPD (2009) included new students enrolled in the program, adjusting to the new environment, medication changes, and staff turnover. These factors can impact the therapeutic environment and the students within said environment. Specifically, when new students transition into the school program, some children test the boundaries and rules within the program more than do other children who are established in the program. In addition, when medications are changed, children may experience side effects to these changes, including aggressive behaviors. Furthermore, when new staff begin in the program, the dynamic may shift within the classroom setting between children and staff that may negatively impact the therapeutic environment, as well as lead some children to test the new staff. Considering that these factors may account for variability and may account for a disruption in the therapeutic environment is important. Also, important is a staff that is aware and proactive in the planning for these factors within the therapeutic environment, as they are commonplace in a residential and school treatment setting. Additionally, administration can provide focused trainings to target these factors to allow staff to expand their knowledge and skill in de-escalation techniques. Lastly, specific tools within the Sanctuary Model, such as community meetings, treatment plan conferences, and red-flag meetings, can help facilitate proactive individualized planning for these variables within the therapeutic environment.

A second goal of the study was to examine the possible impact of the Sanctuary Model within the therapeutic environment. Despite statistically nonsignificant results, noteworthy clinical findings were discovered. Specifically, at baseline, staff reported to be less involved within the therapeutic environment, felt less sufficient and independent

in making decisions, and reported less clarity in expectations and rules within the program compared to the normative sample. Furthermore, after 1 year of implementing the Sanctuary Model, only one variable, involvement, remained lower than the normative sample, Involvement, indicating that staff continued to feel less active within the program compared to the normative staff sample. Additionally, results suggest that the remaining variables assessed within the COPES-R were comparative to the therapeutic environment in the normative sample. This outcome suggests that future planning should focus on assessing how staff members can take a more active role in the program to develop their involvement within the therapeutic environment.

These results were similar to those Rivard et al. (2005), who reported no statistically significant differences in the therapeutic environment within the first year of implementation. However, in the Rivard et al. (2005) study, statistically significant improvements occurred after 2 years of implementing the Sanctuary Model in the Support, Spontaneity, Autonomy, Personal-Problem Orientation, and Safety variables. This result suggests that more than 1 year of implementing the Sanctuary Model may be required to begin to see consistent significant benefits within therapeutic environment domains.

Finally, few positive effects were found in the area of job satisfaction after 1 year implementation of the Sanctuary Model. Of the 17 domains assessed, only three areas yielded minimal improvements. These areas were fair pay, less frustration within the environment, and confidence about the individual's future at the site. Additionally, 14 areas measured by the job satisfaction survey indicated a decrease in satisfaction. Though increased job satisfaction has been shown to be a positive outcome measure of the

Sanctuary Model, research investigating the effects of the Sanctuary Model has included long-term outcome studies spanning 3 or more years of model implementation (Banks & Vargas, 2009). This result suggests that changes in job satisfaction may require a longer time period of implementation to yield more positive results.

Interestingly, Spagnoli, Caetano, and Santos (2012) assessed job satisfaction factors over a 6 year period while an organization underwent restructuring, and results revealed that the following specific job satisfaction factors had slow positive trends: management practice satisfaction, work climate satisfaction, and work itself satisfaction. However, the reward satisfaction variable remained stable across time, indicating some factors such as dispositional factors, within job satisfaction are more stable than others. Additionally, statistically significant changes in job satisfaction may not occur over a short-term 1 year study and may require time and continued monitoring and adjustments within the environment.

Dispositional and situational factors affect job satisfaction over time. Specifically, staff turnover, managerial turnover, personality styles, and mandated program implementation may have impacted the dynamics within the school this past year. It is important to note and discuss the factors that may impact change and job satisfaction over time. One of main indicators for decreased job satisfaction and turnover in teaching is work conditions, specifically, autonomy, administrative support, and students with discipline problems (Liu & Ramsey, 2008). Furthermore, the factors that may have impacted job satisfaction within the program are consistent with the literature on teachers' job satisfaction previously noted. Anecdotally, during the introduction of the implementation process of the Sanctuary Model, the program director noted staff reported

an inability to see value in the model. In addition, some felt as if the implementation process was an added job responsibility without increased compensation, which is a consistent perception found in literature on teachers' job satisfaction (Liu & Ramsey, 2008). Additionally, Beer, Eisenstat, and Spector (1990) noted reluctance from employees to commit to organizational change because change was perceived as intrusive and disruptive of their routine, which is consistent with anecdotal reports from the site's supervisory and direct-report staff.

Similar initial qualitative responses were also noted in a previous study implementing the Sanctuary Model (Rivard et al., 2005). Furthermore, implementing the Sanctuary Model fostered program changes that required adjustment (e.g., daily community meetings). Changes within a program can create uncertainty and pushback, which can negatively impact job satisfaction in the short term. In addition, some teachers and a supervisor resigned during the year. This change in staffing required teachers and assistants to work with less administrative and clinical support, possibly negatively impacting job satisfaction (Liu & Ramsey, 2008). Because limited positive job satisfaction was noted during the first year of implementation of the Sanctuary Model, job satisfaction should be further evaluated throughout the continued implementation of the model. Consideration should be given to further monitoring and analyzing job satisfaction and the staff's current view of the Sanctuary Model to assess if value of the model is understood and supported, as well as to address any arising questions or concerns.

When considering the overall changes that are required for agencies to implement the Sanctuary Model, one has to consider the literature on the effects and expectations of

organizational change. Prior research outlines that involvement in planned organizational change is a long process, emotionally intense, and fatiguing for staff (Buono & Bowditch, 1989; Fugate, Kinicki, & Prussia, 2008). Moreover, 50% of all organizational changes have failed to produce the results expected once the change was implemented (Marks, 2006). Furthermore, empirical studies confirm that employees' attitudinal and behavioral reactions impact the success of organizational change. Specifically, researchers found that change-related attitudes and behaviors were directly related to an organization's post change performance (Kim & Mauborgne, 2003; Robertson, Roberts, & Porras, 1993). Shin, Taylor, and Seo (2012) proposed that one way to increase and maintain employees commitment to change is by increasing individual resources prior to the start of the change process. Their findings showed that employees who believed that they had higher levels of organizational inducements were more committed to the organizational change compared to employees who perceived fewer inducements and resources. The research concluded that the resources helped employees experience positive affect, which influenced the change process and outcomes after the change took place.

As discussed previously, there were anecdotal reports from staff who participated in the implementation of the Sanctuary Model indicated that some had difficulty perceiving the value in implementing the model and believed that the changes increased their workload and added stress. This reluctance may lend evidence to the need for increased supports and direction from the Sanctuary Institute in the pre-implementation stage to ensure the development of attitudinal and behavioral commitment for the changes and preparation for any additional resources that could alleviate reluctance for

change. Additionally, organizations should prepare internally for the long process and inherent stress that employees experience while working through organizational change.

Limitations

There are multiple limitations to the current study. One limitation in the current study is the small number of participants. A study that has few participants lacks the necessary power to detect significant results, if they exist. Though the number of participants was small, the primary purpose for the implementation of the Sanctuary Model at the site was to pilot the program prior to using it across the entire organization. Implementing the Sanctuary Model in the EES program enabled the Sanctuary committee at the site to manage the process on a smaller scale and evaluate program outcomes prior to initiating the model throughout the organization. Therefore, program evaluation limited the sample size to those participating in the specific program.

Another limitation of the study is the brief period of data collection, a 1-year interval. Many of the published studies discuss the implementation of the Sanctuary Model after a 2 to 3 year period (Banks & Vargas, 2009; Madsen et al., 2003). Because of the relatively short duration of this study, the final outcome of the implementation of the Sanctuary Model may have not been fully encapsulated. Despite the limited research on the short-term outcomes of the Sanctuary Model, both the short and long-term effects are important to evaluate. By studying the short and long-term outcomes, researchers can assist the Sanctuary Committee and future facilities in managing the implementation process by providing qualitative and quantitative data regarding the process. In addition, researchers can provide recommendations for how the Sanctuary Committee can further assist providers, specifically during different phases of the implementation process.

Finally, the current study relied solely on one student variable to measure the impact of the Sanctuary Model on the students' perspective in the school, restraint frequency. The limited student measurement is a limitation because the model could have affected many other factors within the therapeutic environment. Using a circumscribed measure of restraint frequency does not provide a comprehensive understanding of all of the dynamics and factors important to a treatment environment. The narrow focus of assessment did not account for students who may have experienced other positive effects, such as decreased levels of symptoms, increased treatment compliance within the program, increased sense of safety within the school, or decreased length of stay.

Future Directions

Future study of the Sanctuary Model is needed to further evaluate its potential as a positive influence on the therapeutic environment. Although the Sanctuary Model originated in the inpatient hospital setting, other settings, such as outpatient and residential facilities, have successfully implemented this model (Banks & Vargus, 2009; Jennings, 2004; Bloom, 2005; Yanosy et al., 2009). However, knowledge regarding implementation of the model in community-based programs is limited. Future research should focus on implementing and evaluating in-home and community-based programs within an organization, such as Family Based Services or Behavior Health Rehabilitative Services. Specifically, evaluating outcomes in behavioral health programs that treat individuals and families with intensive needs in home or community-based settings may expand the scope of potential benefits and treatment outcomes to those outside of traditional office or hospital-based settings. By evaluating factors in these treatment settings results may further aid in expanding the potential staff and patient-reported

benefits from the Sanctuary Model, such as improved treatment outcomes; enhanced staff communication; reductions in violence such as restraints use and injuries; increased job satisfaction; improvements in the areas of nonviolence; increased emotional intelligence; social learning; and open communication (Yanosy et al., 2009).

Research should continue to focus on both the short and long-term impact of the Sanctuary Model. Research is needed to further evaluate implementation of the Sanctuary Model in different phases of implementation. This type of evaluation would provide potential sites implementing the Sanctuary Model with recommendations for program continuance as well as markers for potential outcomes in both short and long-term implementation. Future researchers could consider a longitudinal study and publish the progression of the short and long-term effects to understand how to facilitate positive long-term outcomes. At present, research is limited on the Sanctuary Model, which restricts sites understanding of short and long-term barriers and possible recommendations during the implementation process.

Finally, another consideration for future research is utilizing clients' versus staff impressions of the therapeutic environment during the implementation process. Client perspective would provide perspective from both client and staff of both potential positive and negative impacts of implementing the model. Future research can broaden the factors analyzed within the therapeutic environment while implementing the Sanctuary Model with the individual clients within the program. Some possible client-specific therapeutic factors that have not been considered in the existing literature include symptom change in clients, rate of successful discharges, and length of stay in therapeutic programs.

Implications

One goal for both mental-health and educational settings is to reduce and eliminate restraints, while creating the least restrictive therapeutic environment with a focus on recovery. The Sanctuary Model is one potential means to accomplishing this goal in the school setting. If the Sanctuary Model does reduce restraints, then, possibly, it can influence change for other programs and organizations. However, the current study did not find this result in the short-term implementation of the Sanctuary Model.

The therapeutic environment can affect the short and long-term physical and emotional well-being of staff, as well as influence the way services are delivered. Stresses within the therapeutic environment and staff burnout are two areas that can negatively impact the physical and emotional health of those in social-service fields (The Council for Children with Behavioral Disorders, 2009a; Mohr et al., 2010). Maslach et al. (2001) discussed decreased job satisfaction, less productivity, less commitment to the organization, and higher absenteeism as a result of staff burnout. It is critical to acknowledge and implement a model to support and facilitate positive ways to manage potential stressors. By evaluating the staff's perspective of the Sanctuary Model on the therapeutic environment, researchers may gain insight on how to create resiliency and positive coping skills for staff over time.

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